Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL GUIDELINE CLEARINGHOUSE

General

Guideline Title

Contraception for women aged over 40 years.

Bibliographic Source(s)

Clinical Effectiveness Unit. Contraception for women aged over 40 years. London (UK): Faculty of Sexual and Reproductive Healthcare (FSRH); 2017 Aug. 57 p. [232 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Clinical Effectiveness Unit. Contraception for women aged 40 years. London (England): Faculty of Sexual and Reproductive Healthcare (FSRH); 2010 Jul. 26 p. [164 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

NEATS Assessment

National Guideline Clearinghouse (NGC) has assessed this guideline's adherence to standards of trustworthiness, derived from the Institute of Medicine's report Clinical Practice Guidelines We Can Trust.

= Poor = Fair = Good = Very Good = Excellent

Assessment	Standard of Trustworthiness
YES	Disclosure of Guideline Funding Source
	Disclosure and Management of Financial Conflict of Interests
	Guideline Development Group Composition

YES	Multidisciplinary Group
YES	Methodologist Involvement
▮▮▮▮▯	Patient and Public Perspectives
	Use of a Systematic Review of Evidence
▮▮▮▮▮	Search Strategy
▮▮▮▮▯	Study Selection
▮▮▮▮▮	Synthesis of Evidence
	Evidence Foundations for and Rating Strength of Recommendations
▮▮▮▮▯	Grading the Quality or Strength of Evidence
▮▮▮▮▯	Benefits and Harms of Recommendations
▮▮▮▮▮	Evidence Summary Supporting Recommendations
▮▮▮▮▯	Rating the Strength of Recommendations
▮▮▮▮▮	**Specific and Unambiguous Articulation of Recommendations**
▮▮▮▮▮	**External Review**
▮▮▮▮▮	**Updating**

Recommendations

Major Recommendations

The recommendation grades (A-D, Good Practice Point [GPP]) are defined at the end of the "Major Recommendations" field.

What Are the Main Sexual and Reproductive Health Issues Facing Women over 40?

Fertility

Women should be informed that although a natural decline in fertility occurs with age and spontaneous pregnancy is rare after age 50, effective contraception is required until menopause to prevent an unintended pregnancy. (GPP)

Pregnancy

Healthcare practitioners (HCPs) should advise women that pregnancy and childbirth after age 40 confer a greater risk of adverse maternal and neonatal outcomes than in women under 40. (Grade B)

Sexual Relationships

HCPs should discuss sexually transmitted infections (STIs) and sexual health with women over 40. This population should be advised about condom use and protection from STIs even after contraception is no

longer required. (Grade D)

Transition to Menopause

- Women over 40 with a significant change in their bleeding pattern should have appropriate gynaecological assessment and investigations, whether or not they are using a contraceptive method. (GPP)
- Women over 40 should be asked about any urogenital symptoms or sexual issues they may be experiencing. (GPP)

Why Do Women over 40 Need Separate Guidance?

Increased Background Risks

HCPs should inform women over 40 of the age-related increased background risk of cardiovascular disease, obesity and of breast and most gynaecological cancers as this may affect choice of contraceptive method. (GPP)

Suitability of Contraceptive Methods for Women over 40

The United Kingdom (UK) Medical Eligibility Criteria for Contraceptive Use (UKMEC) provides recommendations for the safe use of contraception including conditions particularly relevant to women over 40 such as reproductive cancers and cardiovascular conditions. Please see Tables 2 to 4 in the original guideline document for details regarding the UKMEC.

Can Contraception Affect Menopause?

Women should be informed that contraception does not affect the onset or duration of menopausal symptoms but may mask the signs and symptoms of menopause. (Grade C)

Copper Intrauterine Devices

The Faculty of Sexual & Reproductive Healthcare (FSRH) supports extended use of the copper intrauterine device until menopause when inserted at age 40 or over. (Grade D)

Levonorgestrel Intrauterine System

- Women using a Mirena® levonorgestrel intrauterine system (LNG-IUS) for endometrial protection as part of a hormone replacement therapy (HRT) combination must have the device changed every 5 years. (Grade D)
- Women who have undergone endometrial ablation should be advised about the potential risk of complications if intrauterine contraception (IUC) is used. (GPP)
- The FSRH supports extended use of a Mirena® LNG-IUS for contraception until the age of 55 if inserted at age 45 or over, provided it is not being used as the progestogen component of HRT for endometrial protection. (GPP)

Progestogen-only Implant

Women can be informed that the progestogen-only implant (IMP) is not associated with increased risks of venous thromboembolism (VTE), stroke or myocardial infarction (MI) and has not been shown to affect bone mineral density (BMD). (Grade D)

Progestogen-only Injectable

- Women over 40 using depot medroxyprogesterone acetate (DMPA) should be reviewed regularly to assess the benefits and risks of use. Women over 50 should be counselled on alternative methods of contraception. (GPP)
- Compared to non-DMPA users, women using DMPA experience initial loss of bone density due to the hypoestrogenic effects of DMPA but the evidence suggests that this initial bone loss is not repeated or worsened by onset of menopause. (Grade D)

Progestogen-only Pills

Women can be informed that the progestogen-only pill (POP) is not associated with increased risks of VTE, stroke or MI and has not been shown to affect BMD. (Grade B)

Combined Hormonal Contraception (CHC)

- Combined oral contraception (COC) with levonorgestrel or norethisterone should be considered first-line COC preparations for women over 40 due to the potentially lower VTE risk compared to formulations containing other progestogens. (GPP)
- COC with ≤30 µg ethinylestradiol should be considered first-line COC preparations for women over 40 due to the potentially lower risks of VTE, cardiovascular disease and stroke compared to formulations containing higher doses of estrogen. (Grade C)
- CHC can reduce menstrual bleeding and pain, which may be particularly relevant for women over 40. (Grade A)
- HCPs can offer an extended or continuous CHC regimen to women for contraception and also to control menstrual or menopausal symptoms. (Grade A)
- Women aged 50 and over should be advised to stop taking CHC for contraception and use an alternative, safer method. (GPP)
- COC is associated with a reduced risk of ovarian and endometrial cancer that lasts for several decades after cessation. (Grade A)
- CHC may help to maintain BMD compared with non-use of hormones in the perimenopause. (Grade A)
- Meta-analyses have found a slight increased risk of breast cancer among women using COC, but with no significant risk of breast cancer by 10 years after cessation. (Grade B)
- Women who smoke should be advised to stop CHC at 35 as this is the age at which excess risk of mortality associated with smoking starts to become clinically significant. (GPP)

Other Methods

HCPs should advise women that sterilisation does not alter or eliminate menstrual periods. Women who have been using another method of contraception should be made aware that bleeding patterns may well change after sterilisation because they have stopped a contraceptive method. (Grade D)

Emergency Contraception

Women over 40 who still require contraception should be offered emergency contraception after unprotected sexual intercourse if they do not wish to become pregnant. (GPP)

When Is Contraception No Longer Needed?

Diagnosing Menopause

- Menopause is usually a clinical diagnosis made retrospectively after 1 year of amenorrhoea. Most women do not require measurement of their serum hormone levels to make the diagnosis. (GPP)
- If needed, women over 50 using progestogen-only contraception, including DMPA, can have serum follicle-stimulating hormone (FSH) measurements undertaken to check menopausal status. (Grade D)
- Women using CHC or HRT have suppressed levels of estradiol and gonadotrophins; measuring these hormones does not give accurate information on which to base advice regarding menopausal status and when to stop contraception. (Grade D)

When Should Contraception Be Stopped?

- In general, all women can cease contraception at the age of 55 as spontaneous conception after this age is exceptionally rare even in women still experiencing menstrual bleeding. (GPP)
- If a woman age 55 or over does not wish to stop a particular method, consideration can be given to continuation providing the benefits and risks for her as an individual have been assessed and discussed with her. (GPP)
- IUC should not be left in situ indefinitely after it is no longer required as it could become a focus of infection. (Grade D)

Can Hormone Replacement Therapy Be Used Alongside or in Place of Contraception?

Women using sequential HRT should be advised not to rely on this for contraception. (Grade D)
Women may use a Mirena LNG-IUS with estrogen for up to 5 years for endometrial protection as part of an HRT regimen. Women using Mirena for this purpose must have the device changed every 5 years. (Grade D)
At the present time, POP, IMP and DMPA are not licensed for and cannot be recommended as endometrial protection with estrogen-only HRT. (GPP)
All progestogen-only methods of contraception are safe to use as contraception alongside sequential HRT. (GPP)
CHC can be used in eligible women under 50 as an alternative to HRT for relief of menopausal symptoms and prevention of loss of BMD. (GPP)

Definitions

Grading of Recommendations

A: At least one systematic review, meta-analysis or randomized controlled trial (RCT) rated as 1++, and directly applicable to the target population; *or* a systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results.

B: A body of evidence including studies rated as 2++ directly applicable to the target population and demonstrating overall consistency of results; *or* extrapolated evidence from studies rated as 1++ or 1+.

C: A body of evidence including studies rated as 2+ directly applicable to the target population and demonstrating overall consistency of results; *or* extrapolated evidence from studies rated as 2++.

D: Evidence level 3 or 4; *or* extrapolated evidence from studies rated as 2+.

Good Practice Point: Good Practice Points based on the clinical experience of the guideline development group (GDG).*

*On the occasion when the GDG finds there is an important practical point that they wish to emphasise but for which there is not, nor is there likely to be, any research evidence. This will typically be where some aspect of treatment is regarded as such sound clinical practice that nobody is likely to question it. It must be emphasised that these are NOT an alternative to evidence-based recommendations, and should only be used where there is no alternative means of highlighting the issue.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Unintended pregnancy

Guideline Category

Counseling

Evaluation

Management

Prevention

Risk Assessment

Clinical Specialty

Family Practice

Internal Medicine

Obstetrics and Gynecology

Preventive Medicine

Intended Users

Advanced Practice Nurses

Nurses

Patients

Physician Assistants

Physicians

Guideline Objective(s)

To update the previous Faculty of Sexual & Reproductive Healthcare (FSRH) guidance and to summarise the available evidence on contraception for women over 40

Target Population

Women over 40 years considering the use of contraception

Interventions and Practices Considered

1. Informing and advising women over 40 about sexual and reproductive health issues
2. Assessment of medical eligibility for contraceptive use
3. Contraception
    - Copper intrauterine devices
    - Levonorgestrel intrauterine system
    - Progestogen-only contraception
    - Combined hormonal contraception (CHC)
    - Sterilisation
    - Emergency contraception
4. Diagnosis of menopause
5. Stopping contraception
6. Hormone replacement therapy used alongside or in place of contraception

Major Outcomes Considered

- Rate of fertility in women over 40
- Pregnancy outcomes in women over 40

- Risk of breast, endometrial, ovarian, or uterine cancer
- Bone mineral density
- Cardiovascular risk
- Relief of vasomotor symptoms
- Risk of venous thromboembolism

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Systematic Review of Evidence

A systematic review of the literature was conducted to identify evidence to answer the clinical questions formulated and agreed by the guideline development group (GDG). Searches were performed using relevant medical subject headings and free-text terms using the following databases: PubMed, EMBASE, Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and POPLINE®. Further, the National Guideline Clearinghouse (NGC) and Scottish Intercollegiate Guideline Network (SIGN) were also used to identify relevant guidelines produced by other organisations; these guidelines were checked to identify missing evidence. No language restrictions were applied to the searches.

Search Date

The databases were initially searched up to 16 June 2017. The evidence identified up to this point was used to develop the first draft of the guideline. Any evidence published after this date was not considered for inclusion.

Search Strategy

The literature search was performed separately for the different sub-categories covered in this clinical guideline. The search terms used are listed in Appendix 1 in the original guideline document.

Articles identified from the search were screened by title and abstract and full-text copies were obtained if the articles addressed the clinical questions relevant to the guideline. A full critical appraisal of each article was conducted. Studies that did not report relevant outcomes or were not relevant to the clinical questions were excluded.

Number of Source Documents

Studies included:

Population, Intervention, Comparator, and Outcome (PICO) 1: 15
PICO 2: 33
PICO 3: 15
PICO 4: 17
PICO 5: 2
PICO 6: 7
PICO 7: 4

PICO 8: 26
PICO 9: 13
PICO 10: 7
PICO 11: 9
PICO 12: 14
PICO 13: 7
PICO 14: 4
PICO 15: 4
PICO 16: 13

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Classification of Evidence Levels

1++: High-quality systematic reviews or meta-analysis of randomised controlled trials (RCTs) or RCTs with a very low risk of bias.

1+: Well-conducted systematic reviews or meta-analysis of RCTs or RCTs with a low risk of bias.

1-: Systematic reviews or meta-analysis of RCTs or RCTs with a high risk of bias.

2++: High-quality systematic reviews of case-control or cohort studies or high-quality case-control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal.

2+: Well-conducted case-control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal.

2-: Case-control or cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal.

3: Non-analytical studies (e.g., case report, case series).

4: Expert opinions.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

The recommendations are graded (A, B, C, D and Good Practice Point) according to the level of evidence upon which they are based. The highest level of evidence that may be available depends on the type of clinical question asked. The Clinical Effectiveness Unit (CEU) adopts the comprehensive methodology developed by the Grading of Recommendations Assessment, Development and Evaluation (GRADE) (http://www.grade workinggroup.org/) to assess the strength of the evidence collated and for generating recommendations from evidence.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Who Has Developed the Guideline?

Development of the guideline was led by the secretariat (Clinical Effectiveness Unit [CEU] staff) and involved the intended users of the guidelines (contraception providers) and patient/service user representatives as part of a multidisciplinary group. The scope of the guideline was informed by a scoping survey conducted amongst members of the Faculty of Sexual and Reproductive Healthcare (FSRH) and amongst service users from three sexual and reproductive health services across the United Kingdom (UK) (Aberdeen Community Health Village [Aberdeen], Scotland; New Croft Centre [Newcastle upon Tyne], England; Victoria Health Centre, Contraception & Sexual Health Clinic [Nottingham], England). The first draft of the guideline was produced based on the final scope of the guideline agreed by the guideline development group (GDG). The first draft of the guideline (version 0.1) was reviewed by the GDG and a revised draft guideline (version 0.2) was produced in response to comments received.

Guideline Development Methodology

This FSRH guideline was developed in accordance with the standard methodology for developing FSRH clinical guidelines (outlined in the FSRH's *Framework for Clinical Guideline Development* [see the "Availability of Companion Documents" field]). The methodology used in the development of this guideline has been accredited by the National Institute for Health and Care Excellence (NICE).

Considerations When Making Recommendations

FSRH clinical guidelines are produced primarily to recommend safe and appropriate clinical practice in relation to the provision of different contraceptive methods. Therefore, when formulating the recommendations, the GDG takes into consideration the health benefits, side effects and other risks associated with implementing the recommendations, based on the available evidence and expert opinion. Further, the GDG takes into consideration the different financial and organisational barriers that clinicians and services may face in the implementation of recommendations to ensure that the recommendations are realistic and achievable.

Reaching Consensus on the Recommendations

When further revisions based on public consultation feedback have been made, members of the GDG were asked to complete a form to indicate whether they agree or disagree with the recommendations proposed. The consensus process is as follows:

> Consensus will be reached when 80% of the GDG members agree with the recommendation.
> Recommendations where consensus is not reached will be redrafted in light of any feedback.
> The recommendation consensus form will be sent again for all recommendations. Consensus will be reached when 80% of the GDG members agree with the recommendation.
> If consensus is not reached on certain recommendations, these will be redrafted once more.
> If after one more round of consultation, consensus is still not reached, the recommendation will be taken to the Clinical Effectiveness Committee (CEC) for final decision.
> Any group member who is not content with the decision can choose to have their disagreement noted within the guideline.

Rating Scheme for the Strength of the Recommendations

Grading of Recommendations

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target population; *or* a systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results.

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D: Evidence level 3 or 4; *or* extrapolated evidence from studies rated as 2+.

Good Practice Point: Good Practice Points based on the clinical experience of the guideline development group (GDG).*

*On the occasion when the GDG finds there is an important practical point that they wish to emphasise but for which there is not, nor is there likely to be, any research evidence. This will typically be where some aspect of treatment is regarded as such sound clinical practice that nobody is likely to question it. It must be emphasised that these are NOT an alternative to evidence-based recommendations, and should only be used where there is no alternative means of highlighting the issue.

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The first draft of the guideline (version 0.1) was reviewed by the guideline development group (GDG) and a revised draft guideline (version 0.2) was produced in response to comments received, after which the it was sent to international and United Kingdom (UK)-based external independent reviewers suggested by the GDG at the face-to-face meeting. A further revision generated a version of the draft guideline (version 0.3) which was placed on the Faculty of Sexual & Reproductive Healthcare (FSRH) Web site for public consultation between 26 June and 24 July 2017. The revised draft guideline (version 0.4) was sent to the GDG for final comments and to reach consensus on the recommendations.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Appropriate decision-making about contraceptive choices for women aged over 40 years

- The copper-containing intrauterine device (Cu-IUD) is a highly effective long-acting reversible contraceptive (LARC) method without hormones or their related side effects; some women may prefer the Cu-IUD for these reasons.
- The 52 mg levonorgestrel intrauterine system (LNG-IUS) offers very significant non-contraceptive benefits. It has been shown to be highly effective in reducing menstrual blood loss. It will also reduce pain associated with primary menstrual pain, endometriosis and adenomyosis. An IUS can also be an effective medical treatment for endometrial hyperplasia.
- The progestogen-only implant (IMP) is the most effective form of contraception available with a 0.05% failure rate and there is no age restriction to its use.
- The main non-contraceptive benefit of the IMP is that it may alleviate menstrual and ovulatory pain.
- Many women find depot-medroxyprogesterone acetate (DMPA) helpful in relation to bleeding patterns.
- Data from observational studies indicate that DMPA may have a potentially protective effect on risk of endometrial or ovarian cancer.
- The desogestrel (DSG) pill may offer some benefits in the management of pain associated with endometriosis, menstruation and ovulation as it suppresses ovulation in most women.

Potential Harms

- Contraception does not affect the timing or duration of menopause but may mask the symptoms that indicate perimenopause or the start of menopause.
- Copper intrauterine devices may be associated with heavier, more painful or prolonged bleeding and so may not be appropriate for women with heavy menstrual bleeding (HMB) or perimenopausal women who experience problematic menstrual bleeding patterns.
- The progestogen-only implant causes irregular bleeding in most women.
- Depot medroxyprogesterone acetate (DMPA) use is associated with a small loss of bone mineral density (BMD) which is usually recovered after discontinuation.
- A systematic review found that there may be a slight increased risk of venous thromboembolism (VTE) for women using DMPA; however, the evidence is limited and the potential risk may only affect women with other risk factors for VTE (e.g., smoking, family history).
- The evidence regarding DMPA and increased breast cancer risk is conflicting. There is possibly a weak association between current use and breast cancer, but any increased risk is likely to be small and reduce with time after stopping.
- The available evidence does not support an association between breast cancer and progestogen-only pill (POP) use. However, due to the fact the evidence is limited, an increased risk cannot be completely excluded. Any increased risk is likely to be small and to reduce with time after cessation.
- Once consideration regarding POP use for women over 40 is the potential for altered bleeding patterns, which affect nearly half of women using POP.
- Meta-analyses have found a slight increased risk of breast cancer among women using combined oral contraception (COC), but with no significant risk of breast cancer by 10 years after cessation.
- There appears to be a small increased risk of cervical cancer associated with COC use (former or current) although the risk of cervical cancer decreases over the age of 40. The increased risk associated with COC use declines after cessation, returning to the same risk as non-COC users after approximately 10 years.
- There is a potential increased risk of stroke and myocardial infarction (MI) for women who use combined hormonal contraception (CHC); however, the available evidence is conflicting and these events are rare.
- Women using CHC are at increased risk of VTE (which includes deep vein thrombosis, pulmonary embolism and cerebral venous sinus thrombosis).

Contraindications

Contraindications

Current guidance contraindicates use of a levonorgestrel intrauterine system (LNG-IUS) for women with previous or current breast cancer; however, some healthcare practitioners (HCPs) may consider the benefits of LNG-IUS use outweigh the risks for some women after specialist review.

Qualifying Statements

Qualifying Statements

The recommendations included should be used to guide clinical practice but are not intended to serve alone as a standard of medical care or to replace clinical judgement in the management of individual cases.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Audit Criteria/Indicators

Staff Training/Competency Material

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Clinical Effectiveness Unit. Contraception for women aged over 40 years. London (UK): Faculty of Sexual and Reproductive Healthcare (FSRH); 2017 Aug. 57 p. [232 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2017 Aug

Guideline Developer(s)

Faculty of Sexual and Reproductive Healthcare - Professional Association

Source(s) of Funding

This guideline is produced by the Clinical Effectiveness Unit (CEU) with support from the Clinical Effectiveness Committee (CEC) of the Faculty of Sexual & Reproductive Healthcare (FSRH). The FSRH is a registered charitable organisation which funds the development of its own clinical guidelines. National Health Service (NHS) Lothian is contracted to host the CEU in the Chalmers Centre and to provide the CEU's services using ring-fenced funding from the FSRH. No other external funding is received. Chalmers Centre supports the CEU in terms of accommodation, facilities, education, training and clinical advice for the members' enquiry service. As an organisation, NHS Lothian has no editorial influence over CEU guidelines, although staff members may be invited to join the CEU's multidisciplinary guideline development groups (GDGs), in an individual professional capacity.

Guideline Committee

Clinical Effectiveness Unit (CEU)

Composition of Group That Authored the Guideline

Guideline Development Group

Secretariat: Dr Ailsa Gebbie, Director, Clinical Effectiveness Unit (CEU); Dr Sarah Hardman, Deputy Director, CEU; Mrs Valerie Warner Findlay, Researcher, CEU

Multidisciplinary Group: Dr Lesley Bacon, Retired Consultant in Sexual and Reproductive Health (Lewisham, SE London); Dr Jenine Bignall, Specialty Trainee in Community Sexual and Reproductive Health (Central and North-West London NHS Trust); Dr Kate Boog, Specialty Trainee in Community Sexual and Reproductive Health (Nottingham Integrated Sexual Health Service); Ms Lesley Cline, Lay representative; Dr Heather Currie, Associate Specialist Gynaecologist (Dumfries and Galloway Royal Infirmary; Chair, British Menopause Society); Dr Alison Fletcher, General Practitioner, Oldham and Specialty Doctor in Sexual Health (Central Manchester Foundation Trust); Dr Jo Hoddinott, Consultant in Sexual and Reproductive Health; Clinical Lead (Hywel Dda University Health Board); Dr Nazia Hussain, General Practitioner, Locum (Aneurin Bevan Health Board, South Wales); Mrs Sally Kelsey, Lead Nurse, Sexual Health and Contraception (Barking, Havering and Redbridge University Hospitals NHS Trust); Dr Ulrike Sauer, Consultant in Sexual and Reproductive Health, (Margaret Pyke Centres)

Financial Disclosures/Conflicts of Interest

Declaration of interests

Dr Currie has received educational grants, advisory board, speaker and advertising fees from pharmaceutical and non-pharmaceutical companies which support the running and development of Menopause Matters Ltd. Dr Sauer conducted general practitioner (GP) training with LOC IUC which was funded by Bayer. Dr Bateson has attended expert forums and presented at educational sessions for Bayer Healthcare and MSD; she has been supported to attend conferences by these two companies but never received any personal remuneration for these services. Dr Nelson declares the following interests: Grants/Research: Agile, ContraMed, Bayer, Merck; Honoraria/Speakers Bureau: Allergan, Aspen Pharma, Bayer, Merck; Consultant/Advisory Board: Allergan, Agile, Bayer, ContraMed, Intrarosa, Merck.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Clinical Effectiveness Unit. Contraception for women aged 40 years. London (England): Faculty of Sexual and Reproductive Healthcare (FSRH); 2010 Jul. 26 p. [164 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the Faculty of Sexual and Reproductive Healthcare (FSRH) Web site .

Availability of Companion Documents

The following is available:

> Clinical Effectiveness Unit. Framework for developing clinical guidelines. London (UK): Faculty of Sexual and Reproductive Healthcare (FSRH); 2016 Oct. 15 p. Available from the Faculty of Sexual and Reproductive Healthcare (FSRH) Web site .

Questions for continuing professional development and auditable outcomes are available in the original guideline document .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI on July 5, 2005. This summary was updated by ECRI Institute on March 8, 2011. This summary was updated by ECRI Institute on January 23, 2018. The guideline developer agreed to not review the content.

This NEATS assessment was completed by ECRI Institute on November 27, 2017. The guideline developer agreed to not review the content.

Copyright Statement

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